Sample Letter for Maternity-Only Deductible or Co-Payment

Applicant's Name: _____

Address: _____

City, State, ZIP: _____

Phone Number : _____

FMN# (If you have it): _____

Today's Date: _____

Medi-Cal Access Program
P.O. Box 15559
Sacramento, CA 95852-0559

Dear Medi-Cal Access Program,

I declare that I have health insurance that covers my pregnancy. The dollar amount of my deductible or co-payment specifically for maternity-only services is:

_____.
(Indicate deductible or co-payment dollar amount)

The information provided above is true and correct to the best of my knowledge and belief.

Sincerely,

_____
Signature of person applying for Medi-Cal Access Program